

**ENROLLMENT/SERVICE DELIVERY PROCESS**

By signing this authorization, I acknowledge that I have read and understand the information for collection and sharing of data contained on the forms. The authorization will remain in effect no longer than 12 months from the date of my signature.

\_\_\_\_\_  
Signature of parent/legal guardian/ participant (if 18+ years of age or emancipated minor)

\_\_\_\_\_  
Date

Signature of Witness: \_\_\_\_\_

\_\_\_\_\_  
Date:

I understand that I have the right to revoke this authorization, if the revocation is in writing, except to the extent that action has been taken in reliance on this authorization.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law